Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Minnesota Personal Care Services

Focused Program Integrity Review

Final Report

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of the Minnesota Medicaid personal care services (PCS). The objective of the review was to assess the level of program integrity oversight of Medicaid PCS at the state level. A secondary objective of the review was to provide the state with useful feedback, discussions and technical assistance resources that maybe used to advance the program integrity in the delivery of these services.

Background

Medicaid PCS (sometimes referred to as personal attendant or personal assistance services) includes a range of assistance services provided to beneficiaries with disabilities and chronic conditions of all ages. Provision of these services in the beneficiary's home is intended to serve as an alternative to institutionalization. Assistance may either be in the form of direct provision of a task by the personal care attendant (PCA) or cuing/prompting by the PCA so that the beneficiary may perform the task. Such assistance most often involves activities of daily living (ADLs) such as eating, drinking, bathing, dressing, grooming, toileting, transferring, and mobility. Services offered under Medicaid PCS are an optional benefit, except when they are medically necessary for children who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit that provides comprehensive and preventive health care services.

Pursuant to the regulations found at 42 CFR 440.167 PCS is a Medicaid benefit furnished to eligible beneficiaries according to an approved Medicaid state plan, waiver, or section 1115 demonstration. States administer their Medicaid programs within broad federal rules and according to requirements of the specific authority approved by CMS. Services must be approved by a physician, or some other authority recognized by the state. Personal care beneficiaries cannot be inpatients or residents of a hospital, nursing facility, intermediate care facility for the developmentally disabled or institution for mental disease. Services can only be rendered by qualified individuals, as designated by each state.

Methodology of the Review

In advance of the onsite visit, CMS requested that Minnesota complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. In addition, questionnaires and review guide modules were sent to PCS providers and/or provider agencies in order to gain an understanding of their role in program integrity. A three-person review team has reviewed these responses and materials in advance of the onsite visit.

During the week of June 4, 2018, the CMS review team visited the Minnesota Department of Human Services. They conducted interviews with numerous state staff involved in program integrity and administration of PCS. In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the state's program integrity practices with regard to PCS.

Results of the Review

The CMS team identified areas of concern with the state's PCS program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible. These issues and CMS's recommendations for improvement are described in detail in this report. In addition, CMS has included technical assistance resources for the state to consider utilizing in its provision of PCS.

Section 1: Personal Care Services

Overview of the State's PCS

The Minnesota Department of Human Services (DHS) is the single state agency designated to administer the Medicaid program under title XIX of the Social Security Act. The state's federally approved Medicaid state plan provides the authorization for rendering PCS in Minnesota. The Minnesota DHS provides Medicaid state plan PCS to eligible beneficiaries as a traditional fee-for-service (FFS) state plan benefit.

The waiver PCS benefit and managed care organization (MCO) PCS benefit is administered by DHS through 1915(c) waiver and section 1115 Medicaid demonstration authorities. Minnesota's current 1915(c) home and community-based services (HCBS) waiver programs include: Brain Injury, Community Alternative Care, Community Access for Disability Inclusion, Developmental Disabilities, and Elderly Waiver. The Alternative Care waiver program is covered by their section 1115 Medicaid demonstration waiver authority. The PCS benefit is administered to eligible beneficiaries under a traditional FFS methodology for those enrolled in HCBS waiver programs and capitation payments made to MCOs that are responsible for paying individual PCS agencies providing services to that MCO's enrollees, to include those enrolled within the self-directed PCS benefit. Minnesota requires authorization for all PCA services and pays the state plan rate for PCA services regardless of whether the services are approved through a state plan authorization or an HCBS waiver authorization.

In Minnesota there are approximately 132 lead agencies (county or tribal nation) that administer HCBS waiver programs. The DHS has oversight responsibility over the lead agencies. The lead agencies administer long-term care consultation assessment and support planning services. Each lead agency uses certified assessors who have completed Minnesota Choices (MnCHOICES) training and the certification processes determined by the commissioner. The MnCHOICES is a web-based application that is comprehensive and integrates assessment and support planning for Minnesotans who need long-term services and supports. The MnCHOICES embraces a person-centered approach to ensure services meet each person's strengths, goals, preferences, and assessed needs. Certified assessors are required to demonstrate best practices in assessment and support planning including person-centered planning principles and have a common set of skills that must ensure consistency and equitable access to services statewide. A lead agency may choose, according to departmental policies, to contract with a qualified, certified assessor to conduct assessments and reassessments on behalf of the lead agency. Certified assessors must

use person-centered planning principles to conduct an interview that identifies what is important to the person, the person's needs for supports, health and safety concerns, and the person's abilities, interests, and goals. If a person has more complex health care needs, the assessor must consult with a public health or registered nurse.

The MnCHOICES certified assessors are persons with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience, or a registered nurse with at least two years of home and community-based experience who has received training and certification specific to assessment and consultation for long-term care services in the state. According to 42 CFR § 440.167, PCS should be authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the state) otherwise authorized for the individual in accordance with a service plan approved by the state. The DHS elected to utilize a Certified Assessor instead of a Primary Care Physician to authorize services to beneficiaries. During the interview with one of the MCOs it was stated that the Certified Assessors are inconsistent in their recommendations for assessing the needs of the beneficiaries.

Minnesota administers Medicaid PCS to eligible beneficiaries under the state plan, 1915(c) waiver, and section 1115 Medicaid demonstration authorities. The provision of PCS in the beneficiaries' homes or community settings is intended to serve as an alternative for individuals who would otherwise require institutional care.

Summary Information of the PCS State Plan Services and/or Waivers Reviewed

Table 1.

Program Name/ Year Implemented	State Plan or Waiver Type	Service or Program	Administered By
State Plan PCS Implemented over 30 years ago, approximately July 1, 1987	State Plan	State Plan PCS	Minnesota Department of Human Services
Brain Injury Implemented 04/01/1992	Section 1915(c)	Brain Injury	Minnesota Department of Human Services
Community Alternative Care Implemented 04/01/1985	Section 1915(c)	Community Alternative Care	Minnesota Department of Human Services
Community Access for Disability Inclusion Implemented 10/01/1987	Section 1915(c)	Community Access for Disability Inclusion	Minnesota Department of Human Services
Developmental Disabilities Implemented 07/01/1984	Section 1915(c)	Developmental Disabilities	Minnesota Department of Human Services
Elderly Waiver Implemented 07/22/1982	Section 1915(c)	Elderly Waiver	Minnesota Department of Human Services
Alternative Care Implemented 10/18/2013	Section 1115	Alternative Care	Minnesota Department of Human Services

As previously mentioned, Minnesota currently administers PCS under the state plan. The state plan PCS benefit was implemented July 1, 1987. The PCS provided under the state plan are provided for beneficiaries who live in their own home if their own home is not a hospital, nursing facility, intermediate care facility for persons with mental retardation (ICF/MR), institution for mental disease, or licensed health care facility.

Beneficiaries who are eligible may use approved units of PCS outside the home when normal life activities take them outside the home. Personal care services are administered to beneficiaries who are able to direct their own care or to a beneficiary for whom there is a responsible party if the recipient cannot direct his or her own care. Because of this, Minnesota considers all PCS services to be "consumer directed." State plan beneficiaries have a choice between two PCS models for selecting services. They can choose to receive services via a traditional agency model or a PCS Choice option. Within the traditional agency option the personal care agency provides or assists with providing personal care assistance services, and under the PCS Choice option beneficiaries are allowed to recruit, hire, terminate, and train their PCAs.

Minnesota also has five Medicaid waivers that provide service funding and individualized supports to eligible members. The Brain Injury (BI) waiver is authorized under 1915(c) of the Social Security Act. The BI waiver program was implemented on April 1, 1992. The BI waiver program in Minnesota is intended for children and adults with a diagnosis of brain injury who require the level of care provided in a specialized nursing home or neuro-behavioral hospital to receive services in community settings rather than in a nursing facility or a neuro-behavioral hospital. The BI allows a state to provide supports and services to individuals in their home or community setting, rather than in an institutional setting. Applicants must be under 65 years of age at the time they are authorized to receive the BI waiver, be eligible for Medical Assistance (MA), be certified disabled by the Social Security Administration or State Medical Review Team (SMRT) process, have a documented diagnosis of traumatic or acquired brain injury, experience significant or severe behavior and cognitive deficits related to the brain injury, be assessed through a screening process and determined to need the level of services provided in a specialized nursing facility or neuro-behavioral hospital, and have an assessed need for supports and services beyond those available through the standard MA benefit set.

The Community Alternative Care (CAC) waiver is authorized under 1915(c) of the Social Security Act. The CAC waiver program was implemented on April 1, 1985, and provides HCBS as an alternative to institutionalization that promotes the optimal health, independence, safety, and integration of a person who is chronically ill or medically fragile and who would otherwise require the level of care provided in a hospital. In order to be eligible for the CAC waiver, a person must choose the CAC waiver and meet all of the following criteria: be eligible for MA, be certified disabled by the SSA or through the SMRT process, be under age 65 at the time of opening to the waiver, be determined by the case manager/service coordinator to meet the hospital level of care criteria, be certified by the primary physician to meet the level of care provided in a hospital, and have an assessed need for supports and services over and above those available through the state plan.

The Community Access for Disability Inclusion (CADI) waiver is authorized under 1915(c) of the Social Security Act. The CADI waiver program was implemented on October 1, 1987, and provides services for HCBS beneficiaries as an alternative to institutionalization that promote the optimal health, independence, safety, and integration of a person who would otherwise require the level of care provided in a nursing facility. In order to be eligible for the CADI waiver, a person must choose the CADI waiver and meet all of the following criteria: eligible for MA, certified disabled by the SSA or the SMRT process, be under age 65 at time of opening to the waiver, be determined by the case manager/service coordinator to need nursing facility level of care, and have an assessed need for supports and services over and above those available through the state plan.

The Developmental Disabilities (DD) waiver is authorized under 1915(c) of the Social Security Act. The DD waiver program was implemented on July 1, 1984, and provides HCBS services as an alternative to institutionalization that promote the optimal health, independence, safety and integration of a person who meets the waiver eligibility criteria and who would require the level of care provided in an Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD). In order to be eligible for the DD waiver, a person must meet all of the following criteria: eligible for MA based on a disability diagnosis, have a developmental disability or a

related condition as defined in Minn. R. 9525.0016, subpart 2, determined by the case assessor to meet the ICF/DD level of care criteria, require daily interventions, daily service needs, a 24-hour plan of care that is specified in the community support plan, assessed to need a residential habilitation service that must be included in the person's community support plan, have made an informed choice of waiver services instead of ICF/DD services, and have an assessed need for supports and services over and above those available through the state plan.

The Elderly Waiver (EW) is authorized under 1915(c) of the Social Security Act. The EW program was implemented on July 22, 1982, and provides HCBS services for people age 65 and older who require the level of care provided in a nursing home and choose to live in the community. The EW promotes community living and independence with services and supports that address each person's individual needs and choices. The EW offers services that go beyond what is available through MA. In order to be eligible for the EW a person must choose and receive at least one home and community service in addition to case management through EW, be a Minnesota resident, be age 65 or older, be assessed by a long-term care consultation (LTCC) to need a nursing facility level of care, be eligible for payment of long term care under MA, have a community support plan that can reasonably assure health and safety, be within the individual budget established by the person's case mix classification, and pay a waiver obligation if applicable.

The Alternative Care (AC) waiver is authorized under section 1115 demonstrative waiver. The AC waiver program was implemented on October 18, 2013, and provides services for people age 65 years and older who require the level of care provided in a nursing home, choose to live in the community, and are not yet financially eligible for Medical Assistance. In order to be eligible for the AC program, a person must choose to receive community services, be a Minnesota resident, be a U.S. citizen or U.S. National, be able to pay a fee (if applicable), be assessed by a LTCC in need of nursing facility level of care, have a community support plan that can reasonably assure health and safety, be within the individual budget established by the person's case mix classification, have income and assets to sustain no more than 135 days of nursing facility services, have no other payer for needed community-based services, and not be currently eligible for medical assistance.

Medicaid and PCS Expenditure Information

Minnesota's total Medicaid expenditures in federal fiscal year (FFY) 2017 were approximately $11.16 billion and covered almost 1,038,663 beneficiaries. Minnesota's total Medicaid expenditures for PCS in FFY 2017 was approximately $860.6 million. The unduplicated number of beneficiaries who received PCS in FFY 2017 was 29,077. Total unduplicated beneficiaries represents the count of unique individuals receiving PCS during a specified time period. The number of PCS providers enrolled in FFY 2017 was 565. Minnesota participates in Medicaid expansion. The Federal Medical Assistance Percentage for Minnesota for FFY 2017 was 50 percent.

Table 2.

Waiver Authority Service/Program	FFY15	FFY16	FFY17
Alternative Care Community-Based Services	$6,202,968.53	$6,471,656.65	$7,558,816.00
Brain Injury	$4,046,428.81	$4,450,525.18	$4,400,073.68
Community Access for Disability Inclusion	$121,840,282.34	$145,489,188.49	$166,698,764.92
Community Alternative Care	$3,949,246.44	$4,582,278.57	$5,853,883.26
Developmental Disabilities	$20,702,517.71	$27,373,757.09	$31,577,050.93
Elderly Waiver	$3,688,315.36	$3,835,535.01	$4,253,042.06
State Plan FFS PCS Expenditures	$ 597,396,789.66	$ 638,261,924.57	$ 640,218,625.76
Total	$ 757,826,548.85	$ 830,464,865.56	$ 860,560,256.61

*Rate changes are the result of legislation.

The PCS expenditures overall remained consistent with some gradual increases/decreases demonstrated during the three FFYs reviewed. However, Community Access for Disability Inclusion experienced an almost 36 percent increase in expenditures from FFY 2015 to FFY 2017. The CADI beneficiary enrollment in FFY15 was 5,396 and by FFY 17 increased to 7,590 beneficiaries. This increase of 2,194 new beneficiaries or 40 percent change was attributed to the overall growth in beneficiaries requesting and receiving services under this waiver.

The DHS does not have state plan or waiver authority for self-directed care. Minnesota considers all PCA services to be directed by the recipient, or "consumer-directed" and administers PCA services using two models. As previously mentioned, the PCA Choice model affords the beneficiaries the decision-making authority to recruit, hire and train, the individuals who furnish their services. In both models, beneficiaries do not have decision-making authority over how the Medicaid funds in their service budget are spent, instead they have decision-making authority over the utilization of services units. Supervision is provided by the PCA Agency in both models.

Table 3.

Waiver Authority Service/Program	**FFY15**	**FFY16**	**FFY17**
Alternative Community-Based Services	579	566	665
Brain Injury	138	149	151
***Community Access for Disability Inclusion	5,396	6,632	7,590
Community Alternative Care	120	130	156
****Developmental Disabilities	954	1,237	1,333
Elderly Waiver	398	438	472
**State Plan FFS	19,920	19,383	18,710
Total Agency-Directed Unduplicated Beneficiaries	**27,505**	**28,535**	**29,077**

*Unduplicated beneficiary count is the number of individuals receiving services, not units of service.
**The decrease in state plan services was attributed to a growing demand and access to other waiver services.
***Legislated enrollment limits expired July 1, 2015, for the CADI waiver. Observed growth is consistent with forecasted expectations based on historical trends and legislative changes.
****Enrollment limits were modified July 1, 2014, and again on July 1, 2015, for the DD waiver.

Overall, PCS expenditures and the number of unduplicated beneficiaries receiving PCS services remained constant with some gradual changes during the three FFYs reviewed. The CMS review team noted that the CADI waiver had the largest increase in number of unduplicated beneficiaries receiving services. The state plan PCS program continues to have the highest number of unduplicated beneficiaries receiving services and the highest overall expenditures, however, state plan PCS only saw a seven percent increase in expenditures, largely due to a six percent decrease in beneficiary enrollment for the three FFYs. The CADI waiver provides services for HCBS beneficiaries as an alternative to institutionalization that promote the optimal health, independence, safety, and integration of a person who would otherwise require the level of care provided in a nursing facility. In order to be eligible for the CADI waiver, a person must choose the CADI waiver and meet all of the following criteria: eligible for MA, certified disabled by the SSA or the SMRT process, be under age 65 and meet nursing home level-of-care to qualify for services. The next highest number of unduplicated beneficiaries who were receiving services not enrolled in the state plan or CADI waiver, were enrolled within the DD waiver, which required beneficiaries to have a disability diagnosis and have a developmental disability or a related condition. The other additional HCBS waivers required the beneficiaries meet a higher level of need, or special requirement, in addition to other medical diagnoses to qualify for services, thus causing a lower number of beneficiaries to be enrolled.

State Oversight of PCS Program Integrity Activities and Expenditures

The DHS delegates certain administrative functions for PCS to lead agencies (counties and tribes) and managed care organizations. The DHS Disability Services policy area for PCA services provides technical assistance to service beneficiaries, providers, and lead agencies (county/tribe/MCO). The DHS also maintains a Surveillance and Integrity Review Section (SIRS) within its Office of Inspector General. The SIRS conducts post-payment reviews of claims submitted by health care providers participating in Minnesota's publicly funded health care programs, including PCS providers. The SIRS operates in accordance with federal regulations and currently maintains a staff of 44 full time equivalents. Currently, there is no formal intra-agency agreement, policy or procedures between Disability Services or SIRS outlining the responsibilities for oversight of the PCS program.

Additionally, DHS contracts with MCOs for the delivery of health care services in the Minnesota Health Care Program (MHCP). The contractual provisions require the MCOs to conduct post-payment reviews of provider claims just as SIRS does for FFS claims. All instances of fraud, waste, and abuse are required to be reported to DHS by the MCOs. The DHS has developed extensive reporting forms that require submission of tips, investigations, adverse actions, and monetary recoveries by the MCOs' investigative units. Staff within SIRS review these reports and follow up with the individual plans to verify the accuracy of the information reported. All the data related to investigations by the MCOs' investigative units are subject to review by DHS.

The SIRS meets quarterly with the investigative units in joint meetings and visits each of the investigative units individually at the MCO's site.

Table 4.

Agency-Directed and Self-Directed Combined	**FFY** 2015	**FFY** 2016	**FFY** 2017
Identified Overpayments	$1,106,713	$1,326,784	$1,436,471
Recovered Overpayments	$1,137,656	$885,746	$1,338,400
Terminated Providers	38	25	13
Suspected Fraud Referrals	272	332	433
Percentage of Fraud Referrals Made to MFCU	112	116	81

*Overpayments identified and recovered in FFY 2015, FFY 2016, and FFY 2017 include fraud, waste, and abuse.

Overall, Minnesota's activity regarding post payment actions taken was high, but down from the previous two FFYs 112 (FFY15) and 116 (FFY 16). There were eighty-one fraud referrals in FFY17 made to the Medicaid Fraud Control Unit (MFCU). The increase in referrals was due in part to Minnesota's development of a more robust process for the referral of suspected fraud to MFCU. This enhancement has resulted in an increase in overall fraud referrals. There were 13 provider terminations related to PCS in FFY17. Several factors influenced the decrease in the number of terminations. These factors include: the availability of resources to investigate cases, the delay of imposition of administrative sanctions due to pending criminal charges, and the lengthening of the investigative process due to more complex cases. Minnesota also discontinues a provider's ability to provide services in the MHCP by "suspending" their participation in MHCP following misconduct (though this sanction should not be confused with a payment suspension). Additionally, as stated in the questionnaire, Minnesota has imposed over 300 payment suspensions in the last three FFYs.

There were overpayments identified and recovered for all three FFYs. In FFY15 recovered overpayments were more than the identified amount due to collections received from the previous FFY14 identified overpayments. The FFY17 identified overpayments were more than the recovered amount. This figure only reflects money received by the state at the time of the review.

Section 2: Self-Directed / Participant-Directed Care Services

Overview of Participant- Directed Personal Care Services

As previously mentioned, 42 CFR § 441.450 provides participants, or their representatives, the opportunity to exercise choice and control over services. Beneficiaries are afforded the decision-making authority to recruit, hire, train, and supervise the individuals who furnish their services under self-directed care models. Beneficiaries may also have decision-making authority over how the Medicaid funds in their service budget are spent.

Minnesota does not have state plan or waiver authority for self-directed PCS. Minnesota considers all PCA services to be consumer-directed. The DHS requires all PCS to be provided by an enrolled personal care agency or licensed home health agency. Supervision is provided by the PCS agencies in both models of care. Minnesota's Medicaid PCS program includes a consumer-directed option known as "PCA Choice." This option is available to beneficiaries

receiving services under fee-for-service and managed care. Under this option, the consumer is responsible for hiring, training, scheduling, and terminating personal care assistants from their care. The PCA Choice services are billed and the claims logic is applied identically to non-PCA Choice services under both Medicaid FFS and managed care, but there is no distinct procedure code, modifier or provider type used to identify services provided under the PCA Choice model. Specifically, there is no systematic/claims-based way to identify expenditures made under the PCA Choice option, verification of beneficiary's PCA Choice model status can only be determined by checking the care plan through the PCS agency.

State Oversight of Participant- Directed Personal Care Services

Blue Plus advised that health plan care coordinators are assigned to each member age 65 or older and enrolled in the health plan Medicaid products. The care coordinators are responsible, in part, for assessing member needs, informing members of choices available to meet their assessed needs, including self-directed services and supports, and providing support required to meet the member's needs and goals. The care coordinator is responsible for creating a collaborative care plan that coordinates with the community support plan created by the member or his/her representative. This plan is monitored and updated at least twice per year by the care coordinator. Conversations with the member regarding the services, as indicated with the PCS provider, are an integral part of the care plan monitoring and updates.

UCare participates in PCA Choice model, but cannot calculate the number of unduplicated beneficiaries who participated in the PCA Choice model during the last three FFYs due to Minnesota Medicaid not having a claims system based indicator for services delivered under this model. UCare has suggested to the state Medicaid agency (SMA) that assigning a modifier would help alleviate the problem. During the interview with UCare staff it was disclosed that the PCA Choice is high-risk and needs more oversight from the state.

Section 3: PCS Provider Enrollment

Overview of PCS Provider Enrollment

The Provider Screening and Enrollment Unit (PSEU) of DHS is the official enumerator for enrolling and affiliating individual Minnesota's PCA providers for the purpose of identifying the individual PCA who provides the services to beneficiaries on both FFS and MCO claims.

The PCA agencies must enroll individual PCAs with MHCP and affiliate individual PCAs with their agencies. The eligible providers who are both Medicare-certified and comprehensive homecare licensed home health agencies, Personal Care Provider Organization (PCPO), and PCA Choice agencies. The DHS assigns a Unique Minnesota Provider Identifier (UMPI, an NPI equivalent) to the individual PCA during the enrollment process. During the interview with Abbey Care the team observed that correspondence from the SMA to Abbey Care identified a National Provider Identifier (NPI). The team checked the National Plan and Provider Enumeration System (NPPES) and observed that this number was not a registered NPI number. The numerical identifier was a state issued UMPI number, which was not clearly identified as such. The state issues PCA agencies UMPI numbers to use on claims to report the individual as the person who rendered the services to the recipient. Prior to making the request, the PCA

agencies must ensure that each individual PCA they employ meets the personal care assistant criteria, successfully completes individual PCA standardized training requirement, is not excluded on the SAM database, does not appear on the Office of Inspector General (OIG) exclusion list, and successfully completes the background study using NETStudy 2.0 through DHS Background Studies Division.

The DHS also ensures the individual PCA provider is not on the OIG exclusion list and passes the background study with the agency and shares this information with the MCOs on a weekly basis. The DHS requires PCA agencies to comply with data and other information requests from the PCA Quality Assurance (QA) as written in the PCA QA policy.

All providers that choose to enroll to deliver services to MHCP beneficiaries must first complete required training. The agency completes and submits an enrollment packet, provider agreement, and must meet requirements per Minnesota statutes. Provider agreements must be signed by the individual applying for the UMPI number. An officer, administrator, manager, director or person with similar authority must sign a provider agreement for an organization or business. After a PCA agency is enrolled, all individuals who will perform the role of PCAs employed by the agency are required to enroll as individual PCA providers. Information is available on the MHCP website. The DHS also requires the following training sessions for PCA provider agencies prior to approving the agency's enrollment: Steps for Success is required for owners, managing employees and supervisors. A shortened version of the Steps for Success training is required for all qualified professionals working for the agency. Upon approval of enrollment, the agency is also required to ensure someone from their agency attends and completes the PCA billing lab, which is required for the designated billing person, and qualified professional training. The billing lab focuses on all of the rules and requirements of the agency's enrollment with MHCP as it pertains to billing for services. Topics covered include, locating, finding and understanding the rules and requirements, locating resources and instructions, using the software for receiving correspondence about changes and other business information, how to check eligibility, how to submit claims properly (including claims requiring coordination of benefits reporting), how to read and interpret service authorization letters and Remittance Advice (RA), and how to interpret the code sets used on the claims and RA from the Washington Publishing Company website. The training includes information about the PCA program policies and procedures, enrollment requirements of both the agency and the individual PCAs and more specific procedural requirements about the service delivery, authorization, billings and systems and resources available. The providers are allowed to return to the trainings available at any time, to further their knowledge. New employees hired after initial enrollment who are in a role that requires training, are required to complete the training within six months of their hire date.

State Oversight of PCS Provider Enrollment

As required by 42 CFR 455.450, Minnesota has not fully implemented all the screening level provisions, including fingerprinting, based on the assigned level of risk for directly enrolled PCS providers. CMS extended the date of implementation of the Fingerprint- based Criminal Background Checks (FCBC) requirement based on concerns raised by the SMA. The new deadline for implementation of the FCBC requirements are July 1, 2018. Minnesota statute requires that high risk providers or persons with a direct or indirect ownership interest of five

percent or higher in the provider consent to fingerprint-based criminal background checks, however, Minnesota law does not define the fitness criteria that the Minnesota DHS would use for enrollment determinations for these high risk providers, nor does it direct how the background checks will occur. The DHS proposed legislation in 2017 to the Minnesota legislative session allowing it to take actions on the enrollments of high risk providers, using the same background study system and fitness criteria already in effect in Minnesota law for certain MHCP providers.

The proposed legislation will require high risk providers that have not already had the FCBC conducted as part of Medicare enrollment to be studied under the Minnesota Human Services Background Studies statute. Under Minnesota statute 245C, many MHCP providers, as well as individuals seeking licensure in other state programs, are already subject to background studies (BGS). The DHS would use the same fitness criteria for screening of its high risk providers. The proposed legislation addresses any gaps between state defined disqualifications and requirements in federal regulation.

The DHS already has a process for conducting Human Services background studies and is in the process of implementing a fingerprint BGS system called NETStudy 2.0. The implementation for MHCP providers was completed in July 2016. All MHCP providers currently subject to a BGS requirement are expected to be using the fingerprint-based system. The new system includes a rap back-like process (non-biometric based) that provides updated state criminal information through the Minnesota court information system. Updated maltreatment information is also included in the system using data from DHS, the Minnesota Department of Health, and all Minnesota counties. Most MHCP high risk providers are already subject to human services background studies criteria either during their licensing or certification processes, and prior to completing enrollment to provide services with MHCP. Minnesota has a contingency plan with CMS to implement FCBC on PCA provider agencies.

The PSEU ends the provider's ability to receive payment when it learns of a license that is expired, revoked or non-renewed, effective the date the license expired, and sends a termination notice with appeal rights. License data is recorded in MMIS and the team receives a list of licenses that will be expiring and have expired on a monthly basis. The team works these reports monthly. The PSEU enrolls the HCBS providers per the contract with the MCOs. This process includes all actions noted above and monitoring the qualifications of the providers through monthly automated reports from OIG run against data in MMIS, monthly automated job against the System for Award Management (SAM) database and manually worked against the MMIS records, and termination lists monthly to ensure other states or Medicare have not excluded the providers, and notifications from the Background Studies Division of those who need to discontinue working. Additionally, the PSEU takes actions on cases after SIRS determines a provider needs to be suspended or terminated. The unit sends data lists of all providers and their statuses to the MCOs (twice monthly for all providers).

Section 4: Personal Care Service Providers

Overview of the State's Personal Care Service Providers

Providers of PCS deliver supports to Medicaid eligible beneficiaries in their own home or communities who would otherwise require care in a medical institution. These non-medical services assist beneficiaries who have limited ability to care for themselves because of physical, developmental, or intellectual disabilities or conditions. These non-medical services assist beneficiaries with ADLs. According to the state there were 565 PCS providers enrolled in Minnesota for FFY 17. Minnesota does provide unique numerical identifiers to PCAs.

As part of the onsite review, CMS's review team selected four provider agencies and two MCOs to be interviewed. Those agencies were Abbey Care, Accra Care Inc., Circle of Life and Life Companion PCA Inc. The two MCOs interviewed were Blue Plus and UCare.

Oversight of Personal Care Services Providers

Blue Plus

Blue Plus is a Minnesota managed care plan. Blue Plus is a nonprofit and has been providing services to Medicaid eligible residents since early 1990's. Blue Plus has a compliance program in place that complies with federal and/or state regulations. They have a compliance plan and compliance office. Blue Plus has written policies and procedures that outline protocols for reporting, detecting, and preventing fraud, waste, and abuse practices. Blue Plus provided PCS services to 5,032 unduplicated beneficiaries and had expenditures that totaled $83.75 million for FFY17.

Blue Plus did not report any audit findings in the last three FFYs, but did have two referrals of suspected PCS fraud to MFCU. The other identified cases investigated were corrected by adjusting claims and providers were placed on a corrective action plan. Blue Plus reported recovered overpayments of $8,100 in the last three FFYs. Blue Plus recoveries appear to be low, when compared to expenditures of $164.8 million in the last three FFYs.

Blue Plus requires a NPI or UMPI be submitted as part of the incoming claim record. Blue Plus requires a rendering provider ID on all claims submitted. Dates of service and units of service are required on the claim submission. Blue Plus requires rendering PCS information be submitted on all claims, which must also match the DHS PCS agency and PCS enrollment information. Each PCS agency is required to bill separate lines for each date of service with corresponding units. These elements are required for claims payment to a provider. Blue Plus has hundreds of edits in the system to prevent inaccurate claims payment. This includes member, provider, and rendering PCS eligibility checking, duplicate checking, compatibility and validity editing, prior authorization, and medical management editing. These actions by Blue Plus are mitigation efforts to identify problematic PCS claims prior to payment reducing the need for recovery. The SIU does and will continue to conduct investigations of PCS services and recover overpayments where identified.

Blue Plus has a process to perform database exclusion checks on enrolled PCS providers upon initial credentialing, re-credentialing, and on a monthly basis. The compliance team conducts monthly screenings of employees, board members, vendors, members, and providers to prevent payment to any excluded individuals or providers using federal healthcare dollars. Individuals and entities doing business with Blue Plus, or any controlled affiliate, are screened against Office

of Foreign Assets Control (OFAC), OIG, and the General Service Administration (GSA) Excluded Parties List System which include individuals and entities who are excluded from participation in federal healthcare programs. Blue Plus also requires prior authorizations and rendering PCS information to be submitted on all claims, which must also match the DHS PCS agency and PCS enrollment information. The PCS agencies are required to bill separate lines for each date of service with corresponding units. These elements are required for claims payment to a provider. Blue Plus does not require use of an electronic visit verification (EVV) system by the PCS Agencies or their PCAs. Minnesota DHS does not require PCS agencies, managed care entities or PCAs to use or acquire an EVV system. Minnesota DHS does plan to implement this system after January 2019.

UCare

UCare is an independent, nonprofit health plan established in 1984. UCare was the first health plan in Minnesota to offer health care programs for people with disabilities, and currently serves the most members with disabilities of any health plan in Minnesota, with over 6400 enrollees in 38 counties as of FFY17. UCare contracts with over 1,700 PCS providers as of FFY17. The MCO provides these services specifically under two types of plans, the traditional PCS services, and consumer-directed PCA Choice. UCare does have a compliance plan and compliance division as stated in 42 CFR 438.608. Auditing and monitoring tools include: general (recipient) care coordination management, announced supervised nurse visits twice a month, referrals of suspected fraud, waste, and abuse to DHS and the MFCU, state exclusion checks and sanctions, initial assessments and reassessments of beneficiaries, prior authorizations/plan of care (POC), preliminary and post payment reviews/audits of PCS provider agencies and/or PCAs, Point Of Sale pre-payment edits, and verification calls every six months.

Additionally, UCare does not send out benefit verifications for Medicaid enrollees to verify services were rendered. Both traditional and PCA choices services PCS POCs are documented at the PCA Agency's Care Plan level only and not at the MCO. A copy of the POC is also kept in the home. As required by DHS, UCare also refers cases to the MFCU and DHS simultaneously instead of cases being referred to the state first and then referred to the MFCU.

UCare requires all contracted PCS agencies to complete state required online training prior to contract execution, to include training on fraud, waste, and abuse. Additional information is available to PCS agencies on UCare's website, provider portal, and provider manual. UCare PCS providers and individual PCAs are checked monthly against the national and state exclusion databases to ensure continued eligibility status. Also federal background checks and studies are done by the Minnesota DHS initially and daily. Minnesota DHS does not require PCS agencies, managed care entities or PCAs to use or acquire an EVV system. UCare does not require use of an EVV system by the PCS agencies or their PCAs. Minnesota DHS does plan to implement this system by January 2020, the date they are required to implement EVV by the Cures Act.

Accra Care, Inc.

Accra Care, Inc. (hereinafter referred to as Accra) is a nonprofit 501 (c) (3) organization that has been in existence since 1992. Accra was incorporated on July 30, 1992 and began providing PCA services at that time. Accra provides services statewide and works with clients on medical

assistance, disability, elderly waivers, health plans, and private pay. Accra provides PCS services to 100 percent Medicaid beneficiaries through the PCA Choice plan and the PCPO plan, and serves 87 counties in Minnesota. Accra currently provides PCS services to over 4,000 beneficiaries and had over 6,400 employees during FFY17.

Accra has adopted a corporate compliance plan to demonstrate commitment to compliance at all levels. Accra has a Corporate Compliance Officer, in cooperation with other managers within Accra. Accra uses monitoring and auditing systems that are designed to detect non-compliance with the applicable state and federal laws, Accra's standards of conduct, and policies and procedures. Accra monitoring and auditing systems include: assessment of billing systems, in addition to claims accuracy to identify the root cause of billing errors, reviewing billing documentation and clinical documentation in support of claims, and referring areas of concern to the corporate compliance officer, the corporate compliance committee, or quality assurance programs for appropriate reporting, investigation, and corrective action responses. Accra also has employee and client event teams to assist with any administrative, monitoring, or auditing issues that emerge. Accra requires all time sheets to be reviewed and signed by the participant or the responsible party (as mandated by the state), before sending them to Accra for payment and billing.

Accra checks time sheets/service logs on a biweekly basis to ensure PCA's time sheets are accurate before reimbursement or payment to the PCA is disbursed. However, the POC is not attached or verified when timesheets/service logs are checked to ensure the PCA or client's employee billed authorized services as stated on the POC. Accra reports there is no statutory/state requirement for PCA agencies to review and approve the timesheets prior to billing for PCA services. It should also be notated that timesheets are reviewed in the beginning for PCAs initially for a short period of time. Afterwards PCA's timesheets are only reviewed when necessary on seasoned PCAs. Accra states this is performed as a best practice randomly and they primarily rely on the client to confirm the services were rendered. The qualified professional (QP) conducts home visits every 180 days. Service verification calls are only done each quarter for each client by a service verification specialist.

Accra conducts training and education programs to ensure that employees, staff, and subcontractors are fully capable of executing their role in compliance with rules, regulations, and other standards. Also, fraud, waste, and abuse training is incorporated into Accra's training curriculum. This training takes place annually.

Background studies are performed by the state initially. Accra uses the same NETStudy 2.0 wrap back system that is utilized from the state. They also have purchased several fingerprinting devices from the state approved vendor and incorporated their own fingerprinting process. Background checks are consistently and automatically done daily via their connection to the wrap back system at DHS. All federal database exclusion checks are performed in accordance to the regulation at 455.436. Additionally, Accra also checks the MHCP state exclusion databases on a bi-weekly basis for excluded providers. Accra does not require use of an EVV system by their PCAs. Accra is working with a vendor to develop an EVV system. Minnesota DHS does not require PCS agencies, MCOs, or PCAs to use or acquire an EVV system. However,

Minnesota does plan to implement this system after January 2019 to meet the January 2020 federal requirement.

Life Companion P.C.A., Inc.

Life Companion P.C.A., Inc. (hereinafter referred to as Life Companion) is a dual-owner S-Corporation personal care agency that provides PCS one hundred percent to eligible Medicaid beneficiaries (statewide). The PCS agency was first authorized to perform personal care services in July 1991. Life Companion provides PCA Choice and traditional PCS services in the greater twin cities, Minneapolis and Saint Paul, Minnesota, and several other counties to over 272 beneficiaries as of FFY17. Currently they employ over 377 employees as of FFY17. Their organizational structure consists of the owners, the Chief Financial Officer, the Chief Executive Officer, the QPs (Registered and Supervising Nurses), and all other administrative and PCA Staff. Life Companion currently does not have a compliance program, a compliance officer, or compliance committee. Life Companion does have an employee handbook that addresses fraud, waste, and abuse, however, a compliance plan relevant to program integrity plans, procedures, and safeguards does not exist.

Life Companion has auditing and monitoring program tools in place to address fraud, waste, and abuse and program integrity. Life Companion's auditing and monitoring tools include: random personal care assistance service verification calls made by the supervising nurse, supervising registered nurse visits to the client's home to check on the PCAs eight times a year, and the office staff reviews all timesheets/service logs without the plan of cares before submitting claims for reimbursement. No other type of program integrity audits or reviews are performed. Life Companion management additionally communicated to the CMS review team that if they are informed of any misconduct by the PCA they would make a random unannounced visit to the client's home. Management does not make regular visits to the client's home to verify if the PCA is in the home. Life Companion does not do any formal training with PCA staff outside of going over the handbook at the PCA's initial orientation, and supervisory nurse instruction on how to care for the client as stated in the plan of care. The Minnesota DHS trains the QPs and PCAs prior to the PCA providing PCS. Life Companion states they follow Minnesota DHS requirements on initial background studies for new PCAs. The state also contacts Life Companion with any additional fraud, waste, and abuse data on seasoned PCAs. Life Companion does not do as extensive background studies as are conducted at DHS. Life Companion staff only access the OIG database on a monthly basis to check for employees on the exclusion/termination lists. The MHCP state exclusion list is also accessed monthly by Life Companion.

Life Companion does not presently use an EVV system. However, the PCS agency stated that they participated in an EVV pilot program undertaken by an MCO until that program was ended due to the DHS announcing plans for their EVV system in the future. Life Companion staff plan to attend upcoming trainings from the Minnesota DHS on the EVV system.

Circle of Life Home Care

Circle of Life Home Care Anishinaabe (hereinafter referred to as Circle of Life) is a C-corporation doing business in the state of Minnesota since November 2006. They provide PCA services, homemaking, home choice, and respite care in Minnesota through the state's Medicaid state plan and waiver services. Circle of Life focuses on providing in-home care services to Native Americans and has 17 locations in seven different states. During FFY 2017, Circle of Life provided PCS in Minnesota to approximately 1,400 participants, employed approximately 1,500 PCA staff, and 75 supervisory staff.

The agency has an established Compliance Program, a Compliance Officer (currently vacant), and a Compliance Committee that provides guidance to various internal anti-fraud and abuse controls. The compliance efforts for Circle of Life are managed and overseen by the Chief Executive Officer (CEO), Compliance Officer, a Compliance Committee, and the Office Manager/Coordinator for each office. The Compliance Committee consists of the CEO, Compliance Officer, Director of Programs, Executive Director, and several other members of the executive team.

The Compliance Committee establishes an administrative framework for conducting an effective, diligent, and continuous compliance effort throughout the operations and company, creates effective communication channels to deliver the company's commitment to ethical business practices, and a mechanism to receive feedback regarding adherence to these practices. They also outline a commitment to educate the staff and personnel regarding compliance requirements and how to conduct their job activities (duties) in compliance with state and federal laws and according to the policies and procedures of the compliance plan. In addition, they implement monitoring and auditing functions to measure the effectiveness of the compliance plan and to address problems in an efficient and timely manner.

All staff are initially trained by Minnesota DHS through their three-day Steps for Success training program. In addition to initial training that all staff receive with Minnesota DHS, Circle of Life has a training manual that is distributed to all PCAs and Circle of Life requires all PCAs to sign a fraud acknowledgement form that outlines unacceptable fraudulent activities. Circle of Life PCA staff are not required to be licensed. However, each PCA must meet the following requirements and must receive an UMPI: be 18 years of age or older, be employed by a PCS agency, initiate and clear a background check, and enroll with Minnesota DHS as a PCA once all employment criteria have been met. A person the age of 16-17 years old may be a PCA if employed by only one PCA provider agency responsible for compliance with current labor laws and supervised by a QP every 60 days.

Circle of Life's billing/accounting team conducts audits of a random sample of claims submitted and paid. Any errors in overbilling and inaccurate time cards are explained and corrected, while underpayments are verified with the billing manager and corrective action, if timely, is taken. Circle of Life also performs multiple checks in the timesheet submission process to ensure accuracy and consistency. To minimize and even eliminate human errors, both deliberate and accidental, Circle of Life ensures all dates are written in the same format. All activities performed by the PCA must be initialed and must correspond with the POC for the client. The

PCA must only initial on activities that were performed and if a PCA initials any activities not marked in the POC, then the PCA must correct them. Throughout the timesheet recording and submission process, Circle of Life has multiple people including the Office Manager, RN Supervisor, and responsible party checking to ensure the legitimacy of the time and activities. If the client/responsible party needs more help that is not on the POC, then the office reports this to the Supervising RN, who then determines the need for an early reassessment. The office staff verifies that the PCA and the client/responsible party have both signed the timesheet on or after the last day of service. If the date of the signature is before the last day worked then the office contacts the client/responsible party and PCA to verify the hours were worked past this date. If it was, the PCA and/or client/responsible party must correct the date of the signature.

Circle of Life does an initial background check using PACourts.com to get an initial view of the PCA's criminal history in the state of Minnesota. They then enter the PCA into NETStudy 2.0 through the state of Minnesota. During this process, the OIG exclusion database is checked along with Nurse Registry. They also check federal OIG exclusion list monthly for current employed PCAs.

Circle of Life does not have an EVV system. Currently the state of Minnesota does not require it.

Abbey Care Choice, Inc.

Abbey Care Choice, Inc. (hereinafter referred to as Abbey Care) is a corporation providing in-home care services in Minnesota through the state's Medicaid state plan and waiver services. Abbey Care has been providing PCS since March 1997, and 99 percent of their PCS are Medicaid. During FFY 2017, Abbey Care provided PCS to approximately 1,300 participants, employed approximately 1,700 PCA staff, and eleven supervisory staff.

The agency has an established Compliance Program, Compliance Officer, and a Compliance Committee that provides guidance to various internal anti-fraud and abuse controls. The CEO serves as the Compliance Officer. The Compliance Committee consists of at least three members of the Board of Directors and assists the Board of Directors in fulfilling its fiduciary responsibilities relating to Abbey Care' s regulatory compliance activities and to review Abbey Care' s policies and procedures relating to the delivery of quality medical care to patients.

The Compliance Committee, acting through and with the assistance of the Compliance Officer, assists in identifying areas of risk, and monitoring the ongoing effectiveness of the Compliance Program, reviews compliance program policies to ensure they adequately address legal requirements and address identified risk areas, analyzes the effectiveness of compliance education and training programs, and reviews the compliance log for adequate and timely resolution of issues and/or inquiries. In addition, they also assist in identifying areas of potential violations, establishing periodic monitoring/audit programs, and assists in the development of policies addressing remediation of identified problems.

All staff are initially trained by the Minnesota DHS through their three-day Steps for Success training program. However, after the Steps for Success training Abbey Care does not provide any additional fraud, waste, or abuse training for their PCA staff. Abbey Care also relies on

DHS to check the exclusion lists for employees through the OIG website. Abbey Care's PCA staff are not required to be licensed. To receive services, beneficiaries must have an assessment for PCA services provided by a lead agency (county health department, tribal government, or managed care organization). During the assessment the assessor determines if the recipient is able to direct their own care of if they need a responsible party to act on their behalf. In addition, the assessment determines if a need for PCS exist. Some of the services provided include housekeeping, laundry, shopping, running errands, and support with daily life essentials including bathing, dressing, and grooming. Abbey Care does not currently utilize an EVV system.

Additionally, Minnesota requires each PCA to register for an UMPI, be 18 years of age or older, be employed by a PCS agency, initiate and clear a background check, and enroll with the Minnesota DHS as a PCA once all employment criteria have been met. Anyone age of 16-17 years old may be a PCA if they are employed by only one PCA provider agency responsible for compliance with current labor laws and are supervised by a QP every 60 days.

Section 5: Electronic Visit Verification (EVV)

Overview of the State's Electronic Visit Verification (EVV) System

An EVV system is a telephonic and computer-based in-home scheduling, tracking, and billing system. Specifically, EVV documents the precise time and type of care provided by caregivers' right at the point of care. Some of the benefits of utilizing an EVV system include ensuring quality of care and monitoring expenditures.

Minnesota currently does not use an EVV system in-home scheduling, tracking, and billing system. Pursuant to Section 12006 of the 21st Century Cures Act, all states are required to implement an EVV system for PCS by January 1, 2020.

Recommendations for Improvement

- The state should consider developing a process to ensure that proper oversight and efficiency of procedures and processes for county assessors, and MCO care coordinators are in place to ensure consistency in PCS assessments.
- Consider developing detailed oversight responsibilities of each DHS unit responsible for oversight and administration of PCS. A memorandum of understanding, an intra-agency agreement or creating a standard operating procedure that specifies which state unit(s) are responsible for all aspects of PCS monitoring, oversight, and lines of communication between the agencies may be beneficial towards creating a more unified understanding regarding PCS monitoring and oversight responsibilities.
- The state should consider using a modifier, so that its contractors can accurately determine the number of beneficiaries receiving services through the PCS Choice model of its PCS option without having to verify information through a manual process.
- The state should consider augmenting its regular audits and investigations of its consumer-directed PCS option to avoid creating a vulnerability for the state.

- The state should ensure that a National Provider Identifier is not interchanged with the state's Unique Minnesota Provider Identifier.
- The state should continue to work with the PCS providers to ensure that PCS staff are receiving adequate training in identifying, investigating, and referring potential fraudulent billing practices to the state program integrity unit.
- The state should ensure that the implementation of the Fingerprint-based Criminal Background Checks (FCBC) requirement be fully implemented by the required CMS extended date of July 1, 2018.
- The state should require the use of an EVV system as a method to verify visit activity for Medicaid-provided PCS as required under Section 12006 of the 21st Century Cures Act. The EVV system should verify the date of service, location of service, individual providing the service, type of service, individual receiving the service, and the time the service begins/ends.

Section 6: Status of Corrective Action Plan

Minnesota's last CMS Program Integrity review was in July 2014 and the report for this review was issued in December 2015. The report contained 12 findings. Prior to the onsite review in June 2018, the CMS review team conducted a thorough desk review of the corrective actions taken by Minnesota. The state was found to be in compliance with all corrective actions.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Minnesota to consider utilizing:

- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute, which can help, address the risk areas identified in this report. Courses that may be helpful to Minnesota are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Review the document titled "Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services." This document can be accessed at the following link https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Visit and utilize the information found on the CMS' Medicaid Program Integrity Education site. More information can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html.
- Consult with other states that have PCS programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of staff in program integrity issues.

Conclusion

The CMS supports Minnesota efforts and encourages it to look for additional opportunities to improve overall program integrity. The CMS focused review identifies identified areas of concern which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the weaknesses will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for corrected the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already take action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The CMS looks forward to working with Minnesota to build an effective and strengthened program integrity function.